

McBride Dental

Diplomate American Board of Oral Implantology/Implant Dentistry

Michael Z McBride, DDS

955 Boardwalk, Suite 103, San Marcos, CA 92078

760-471-1003 mcbridedental.com doctor@mcbridedental.com

Health History (2 Pages)

Date of last healthcare exam _____ Please list the names and phone# of physicians who are currently providing you care.

Reason for exam _____

Have you been hospitalized in the last 5 years? ___ 1. _____

If yes, reason: _____ 2. _____

_____ 3. _____

Are you currently receiving care? _____ 4. _____

If yes, nature of care: _____ 5. _____

_____ 6. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. We may ask additional questions concerning your health.

Heart Murmur (Mitral valve prolapse)	No	Yes	Cancer (What Kind?)	No	Yes
Rheumatic Fever	No	Yes	Chemotherapy/ Radiation	No	Yes
Heart (Surgery, Disease, Attack or valve replacement)	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Abnormal Heart Condition	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Psychosis	No	Yes
Asthma	No	Yes	Pacemaker	No	Yes
Diabetes	No	Yes	Recurrent Illnesses	No	Yes
Kidney Disease	No	Yes	HIV Positive or AIDS Related Complex	No	Yes
Liver Disease (including jaundice)	No	Yes	STD	No	Yes
Hepatitis, Any Form	No	Yes	Unintentional Weight Gain/ Loss	No	Yes
Rheumatoid Arthritis	No	Yes	Anemia	No	Yes
Joint Replacement (Knee, Hip etc.) How long ago?	No	Yes	Abnormal Bleeding from a Cut	No	Yes
Epilepsy	No	Yes	Slow healing Mouth Sores	No	Yes
Previous Biopsies	No	Yes	Latex Allergy	No	Yes
Are you required to pre-medicate before dental treatment? Not anesthetic				No	Yes
Women: Are you Pregnant				No	Yes
If no, are you planning a pregnancy in the near future?				No	Yes
Are you a nursing mother?				No	Yes
Are you taking birth control pills?				No	Yes
Do you have Abnormal Blood Pressure? If yes what is it usually: S ___ / D ___				No	Yes
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Are you allergic or have you had a reaction to:		
Penicillin or other antibiotics	No	Yes
Aspirin	No	Yes
Codeine, valium or other sedatives	No	Yes
Other _____	No	Yes
Are you a smoker?	No	Yes
If so, how much do you smoke per day? _____		
Do you consume grapefruit juice, grapefruits or grapefruit extract?	No	Yes
Are you taking Tagamet (Cimetidine)?	No	Yes
If so, how often? _____		
Do you take Antacids?	No	Yes
If yes, how often _____		
Do you take Biophosphonates such as Fosamax, Actonel or Boniva?	No	Yes
Are you taking any herbal supplements/medicines?	No	Yes
If yes, which ones _____		
Have you ever taken Fen-Phen or any diet pills?	No	Yes
If yes, have you had a cardiogram? _____ date _____		

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Weight _____

Diet: Restricted Diet _____ How many meals a day _____

Food Allergies _____ Sugar in your diet (circle) none/slight/moderate/high

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

Patient Signature

Date

Michael Z McBride, DDS

Doctor (Print Name)

Doctor Signature

Date